UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
FOURTH REGION

FRIENDS BEHAVIORAL HEALTH SYSTEM, L.P.[1] Employer and PENNSYLVANIA ASSOCIATION OF STAFF NURSES AND ALLIED PROFESSIONALS Petitioner	Case 04–RC–071635

REGIONAL DIRECTOR'S DECISION AND DIRECTION OF ELECTION

The Employer, Friends Behavioral Health System, L.P., is engaged in the operation of a behavioral health hospital, herein called the Hospital, with related group homes at a multi-building facility in Philadelphia, Pennsylvania. The Petitioner, Pennsylvania Association of Staff Nurses and Allied Professionals, seeks to represent a unit of all professional and non-professional employees engaged in direct patient care and employed in the Admissions and Nursing departments and the Greystone Program subject to the requirements of Section 9(b)(1) of the Act, which entitles professional employees to vote whether they wish to be represented in the same unit as nonprofessional employees.[2] More specifically, the Petitioner seeks to represent the full-time, regular part-time and per diem Registered Nurses (RNs), Charge Nurses (CNs), Infection Control and Employee Health RNs,[3] RN Admissions Coordinators II (ACIIs), Mental Health Technicians (MHTs), Licensed Practical Nurses (LPNs) and Nursing Department Unit Clerks who are employed at the Hospital, including the Greystone and Hillside residential facilities, which together constitute the Greystone Program. The Petitioner would exclude all other employees, including RNs who possess RN licenses but do not function as RNs or otherwise engaged in direct patient care. The Petitioner indicates that it will participate in an election in any unit found to be appropriate.

The Employer would exclude all RNs and Charge Nurses (CNs) from any unit found appropriate as supervisors within the meaning of Section 2(11) of the Act. The Employer asserts that RNs assign and responsibly direct the work of MHTs, and that CNs assign and responsibly

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[1] The Employer's name appears as amended at the hearing.

[2] In its brief, the Petitioner agreed that the Nursing Department Unit Clerks and RN ACIIs should be included in the unit.

[3] The parties stipulated that Infection Control and Employee Health RNs should be included in the RN unit.

direct the work of nursing staff, can effectively transfer employees, have the authority to discipline employees, can effectively recommend the hiring of employees, an effectively recommend merit wage increases for employees via their evaluation of employees and can resolve employee grievances.

The Employer contends that if RNs and CNs are found not to be supervisors within the meaning of Section 2(11) of the Act, then the only appropriate unit consists of nonsupervisory RNs, including RNs working in non-RN positions outside the Nursing Department, even when such positions do not require an RN license.[4] The Employer would also exclude per diem RNs from the unit as lacking a community of interest with full-time and regular part-time RNs.

The Employer takes the position that the Petitioner's proposed nonprofessionals also unit of MHTs, LPNs and Unit Clerks is inappropriate and that the nonprofessional unit should include the following classifications of employees who are engaged in clinical operations: Assessment Coordinator I; the Benefits Specialist and the Unit Clerk/Secretary in the Admissions Department; the Administrative Assistants in the Departments of Risk Management and Performance Improvement and Plant Operations/Safety; Medical Records Specialist, Medical Records Clerk, Medical Records Analyst Receptionist/Operator, the nonprofessional Care Manager in the Department of Utilization Management[5]; and the Recreation Therapist.[6] The Employer takes the position that RNs do not share a sufficient community of interest with the nonprofessional employees such that they should be included in an overall unit with the nonprofessionals. Finally, the Employer seeks to exclude per diem employees in any classification.

The Employer also employs physicians, psychiatrists, interns, externs, students, social workers, technical employees other than LPNs, business office clericals, accounting staff, including payroll coordinator, administration department staff, human resources staff, cooks, dietary aides, housekeeping employees, plant operation engineers, maintenance technicians and security guards. The record does not indicate in which department most of these classifications are employed.

A Hearing Officer of the Board conducted a hearing. I have considered the evidence and arguments presented by the parties, and, as discussed below, I have concluded that the Employer has failed to establish that RNs or CNs are supervisors with the meaning of Section 2(11) of the Act. I have also concluded in agreement with the Petitioner that its proposed unit limited to RNs, including CNs and RN ACIIs, and its proposed unit of nonprofessionals employees engaged in direct patient care including LPNs, MHTs and Nursing Department Unit Clerks are appropriate units. In addition, as discussed below, I have concluded that an overall unit of the

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[4] Classifications in which some or all incumbents hold an RN license but do not function as RNs are Clinical Integrity Nurse Auditor and Care Manager

[5] The Employer asserts that Care Managers, except Care Manager Alicia Bolds are professional employees. The Employer contends that Care Manager Alicia Bolds is not a professional employee because she lacks an advanced degree.

[6] The Employer did not address this classification in its brief, nor did it present any evidence with respect to the job duties of this classification. Although the Employer seeks to have his classification vote under challenge, in view of the absence of any evidence as to the duties and functions of recreation therapist, I shall exclude this position from the nonprofessional unit

professional and nonprofessional employees may also be an appropriate unit subject to the professional employees' right to a *Sonotone*[7] election.

To provide a context for my discussion, I will begin this Decision with a brief overview of the Employer's operations. I then will review the factors that must be evaluated in resolving the supervisory and unit issues and present the relevant facts and the reasoning that supports my conclusion.

I. OVERVIEW OF OPERATIONS

The Employer is a 192-bed facility providing treatment for a range of mental illnesses and alcohol and drug addictions. The Employer is situated in a campus environment consisting of multiple buildings. The Employer operates two separate and autonomous long-term residential homes, known as Greystone and Hillside, where it cares for and treats patients with severe and incapacitating chronic mental illness. The Employer's administrative offices are in the Scattergood Building. The Admissions Department, where new patients are screened for admission or possible referral to another treatment provider, is located in the Admissions Building, which is a separate building. The Employer's in-patient nursing units are located in the Tuke and Bonsall Buildings. The long-term residential buildings are within walking distance of the in-patient units. The first floor of the Tuke Building has a 24-bed unit and a 22-bed unit. The second floor has two 24-bed units. All units in the Tuke Building are for a general adult population. The first floor of the Bonsall Building has a 26-bed unit devoted to an intensive care adult population, whose condition is more acute, and a 24-bed unit devoted to an older adult or geriatric population. The second floor has a 24-bed unit devoted to a general adult population and a 24-bed unit devoted to an adolescent population.

The Admissions Department and the in-patient units operate around the clock. They have day, evening and night shifts and staggered shifts as needed.

II. RELEVANT CASE LAW

A. FACTORS RELEVANT TO DETERMINING THE APPROPRIATE UNIT

The Board's procedure for determining an appropriate unit under Section 9(b) is first to examine the petitioned-for unit. If that unit is appropriate, the inquiry ends. *American Hospital Association v. NLRB*, 499 U.S. 606, 610 (1991); *Dezcon, Inc.*, 295 NLRB 109, 111 (1989). If the petitioned-for unit is not appropriate, the Board may examine the alternative units suggested by the parties, but it also has the discretion to select an appropriate unit that is different from the alternative unit proposals of the parties. See *The Boeing Co.*, 337 NLRB 152, 153 (2001); *Bartlett Collins Co.*, 334 NLRB 484 (2001). The Board generally attempts to select a unit that is the smallest appropriate unit encompassing the petitioned-for employee classifications. *Overnite Transportation Co.*, 331 NLRB 662, 663 (2000). It is well settled that the unit need only be *an*

[7] *Sonotone Corp.*, 90 NLRB 1236 (1950)

appropriate unit, not the most appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 418 (1950), enfd. on other grounds 190 F. 2d 576 (2d Cir. 1951). In determining whether a group of employees possesses a separate community of interest, the Board examines such factors as the degree of functional integration between employees, common supervision, employee skills and job functions, interchange of employees, contact among employees, and similarities in wages, hours, benefits, and other terms and conditions of employment. *Home Depot USA*, 331 NLRB 1289 (2000); *Esco Corp.*, 298 NLRB 837 (1990).

In its recent decision in *Specialty Healthcare and Rehabilitation Center of Mobile*, 357 NLRB No. 83 (2011), the Board overruled *Park Manor Care Center*, 305 NLRB 872 (1991), and its 'pragmatic or empirical community of interests approach' to unit determination in the healthcare industry, and returned to its traditional community of interest test, setting forth the principles that apply in cases like this one, in which an employer contends that the smallest appropriate bargaining unit must include additional employees (or job classifications) beyond those in the petitioned-for unit. As explained in *Specialty Healthcare*, the Board first assesses, as in the usual case, whether the petitioned-for employees are "readily identifiable as a group (based on job classifications, departments, functions, work locations, skills, or similar factors)," and next, whether they "share a community of interest after considering the traditional criteria." Id., slip op. at 12–13. If the petitioned-for unit satisfies that standard, the burden is on the employer to demonstrate that the additional employees it seeks to include share an overwhelming community of interest with the petitioned-for employees, such that there "is no legitimate basis upon which to exclude certain employees from" the larger unit because the traditional community of interest factors "overlap almost completely." Id., slip op. at 11–13, and fn. 28 (quoting *Blue Man Vegas, LLC v. NLRB*, 529 F.3d 417, 421, 422 (D.C. Cir. 2008)). The employer does not meet its burden by showing that its proposed unit is also appropriate or even more appropriate than the petitioned-for unit or that some excluded employees may have a community of interest with those who are included. Rather, the employer must show that the proposed unit is a "fractured" unit, i.e., that the combination of employees is too narrow or does not have a rational basis. Id., slip op. at 12–13. The Board will continue to apply established unit presumptions, when appropriate, to find various units to be appropriate. However, the fact that an employer's proposed unit may conform to an established presumption, does not preclude a finding that the petitioned-for unit is also appropriate, and does not relieve the employer of its burden to prove that the petitioned-for unit is a "fractured" unit.

B. FACTORS RELEVANT TO EVALUATING THE SUPERVISORY STATUS OF NURSES AND CHARGE NURSES

The burden of establishing supervisory status is on the party asserting that such status exists. *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706, 711 (2001); *Dean & DeLuca New York, Inc.*, 338 NLRB 1046, 1047 (2003). The party seeking to prove supervisory status must establish it by a preponderance of the evidence. *Dean & Deluca,* above at 1047 (2003). Section 2(11) of the Act sets forth a three-part test for determining whether an individual is a supervisor. Pursuant to this test, employees are statutory supervisors if: (1) they hold the authority to engage in any one of the 12 supervisory functions listed in Section 2(11); (2) their exercise of such authority is not of a merely routine or clerical nature but requires the use of

independent judgment; and (3) their authority is held in the interest of the employer. See *NLRB v. Kentucky River Community Care, Inc.*, above at 712-713; *NLRB v. Health Care & Retirement Corp. of America,* 511 U.S. 571, 573-574 (1994).

The statutory criteria for supervisory status set forth in Section 2(11) are read in the disjunctive, and possession of any one of the indicia listed is sufficient to make an individual a supervisor. *Kentucky River,* above at 713*; Juniper Industries, Inc.*, 311 NLRB 109, 110 (1993). The Board analyzes each case in order to differentiate between the exercise of independent judgment and the giving of routine instructions; between effective recommendation and forceful suggestions; and between the appearance of supervision and supervision in fact. The exercise of some supervisory authority in a merely routine, clerical, or perfunctory manner does not confer supervisory status on an employee. See *J.C. Brock Corp.,* 314 NLRB 157, 158 (1994)*; Juniper Industries*, above at 110. The authority effectively to recommend an action means that the recommended action is taken without independent investigation by superiors, not simply that the recommendation ultimately is followed. See *Children's Farm Home,* 324 NLRB 61 (1997); *Hawaiian Telephone Co.,* 186 NLRB 1 (1970). The Board has an obligation not to construe the statutory language too broadly because the individual found to be a supervisor is denied the protection of the Act. *Avante at Wilson, Inc.,* 348 NLRB 1056, 1058 (2006); *Chevron Shipping Co.,* 317 NLRB 379, 381 (1995). Where the evidence is in conflict or otherwise inconclusive on particular indicia of supervisory authority, the Board will find that supervisory status has not been established, at least on the basis of those indicia. *Dole Fresh Vegetables Inc.,* 339 NLRB 785, 792 (2003); *Phelps Community Medical Center,* 295 NLRB 486, 490 (1989). The sporadic exercise of supervisory authority is not sufficient to transform an employee into a supervisor. See *Kanahwa Stone Co.,* 334 NLRB 235, 237 (2001); *Gaines Electric,* 309 NLRB 1077, 1078 (1992).

In *Kentucky River,* the Court decided, contrary to the Board, that RNs at a residential nursing care facility were supervisors within the meaning of the Act. In determining that the nurses were not supervisors, the Board had found, inter alia, that while they directed the work of nurses' aides, this direction did not involve independent judgment because it was by virtue of the nurses' training and experience, not because of their connection with management. The Court acknowledged that the term "independent judgment" is ambiguous with respect to the *degree* of discretion required for supervisory status and recognized that it was "within the Board's discretion to determine, within reason, what scope of discretion qualifies." 532 U.S. at 713. The Court rejected the Board's analysis, however, because the Board erroneously excluded "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards" from the statutory definition of independent judgment, even where the employees exercised a sufficient degree of discretion to otherwise warrant a supervisory finding. Ibid. In all other respects, the Court left intact the Board's traditional role in drawing the line between the performance of functions which are clerical and routine and assignment and direction that involve a sufficient element of discretion to confer supervisory status.[8] Thus, the Court did not hold that every exercise of professional or technical

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[8] The Court also indicated that "the degree of judgment that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and regulations issued by the employer." Id. at 713-714.

judgment in directing other employees is necessarily an exercise of independent judgment, but recognized that the Board could determine the degree of independent judgment necessary to meet the statutory threshold for supervisory status. Id. at 714.

In the *Oakwood Health Care, Croft Metal,* and *Golden Crest Healthcare Center* decisions, the Board clarified the circumstances in which it will find that individuals exercise sufficient discretion in performing two of the functions listed in Section 2(11) – assignment and responsible direction of work – to justify their classification as statutory supervisors.[9] As clarified in *Oakwood Health Care*, the term "assign" refers to the "act of designating an employee to a place (such as a location, department or wing), appointing an employee to a time (such as a shift or overtime period) or giving significant overall duties, i.e., tasks, to an employee." *Oakwood Health Care* at 689-690. In the health care setting, the term "assign" encompasses the responsibility to designate other employees to particular residents. Id.

In *Oakwood Health Care,* the Board explained "responsible direction" as follows: "If a person on the shop floor has 'men under him,' and if that person decides 'what job shall be undertaken next or who shall do it,' that person is a supervisor, provided that the direction is both 'responsible . . . and carried out with independent judgment." "Responsible direction," in contrast to "assignment," can involve the delegation of discrete tasks as opposed to overall duties. *Oakwood Health Care* at 690-692. But, an individual will be found to have the authority to responsibly direct other employees only if the individual is *accountable* for the performance of the tasks by the other employee. Accountability means that the employer has delegated to the putative supervisor the authority to direct the work and the authority to take corrective action if necessary, and the putative supervisor faces the prospect of adverse consequences if the employees under his or her command fail to perform their tasks correctly. Ibid.

Assignment or responsible direction will, as noted above, produce a finding of supervisory status only if the exercise of independent judgment is involved. Independent judgment will be found where the alleged supervisor acts free from the control of others, is required to form an opinion by discerning and comparing data, and makes a decision not dictated by circumstances or company policy. *Oakwood Health Care,* above at 692-694. Independent judgment requires that the decision "rise above the merely routine or clerical." Ibid.

C. SELF-DETERMINATION ELECTIONS

Section 9(b)(1) of the Act provides that, "[T]he Board shall not (1) decide that any unit is appropriate . . . if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit." Thus, the Act effectively grants professional employees the right to decide by

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[9] The citations to these cases are *Oakwood Health Care, Inc.,* 348 NLRB 686 (2006), *Croft Metals, Inc.,* 348 NLRB 717 (2006), and *Golden Crest Healthcare Center,* 348 NLRB 727 (2006).

majority vote whether they wish to be included in a unit with nonprofessional employees. In *Leedom v. Kyne*, 358 U.S. 184, 191 (1958), the Supreme Court held that Congress "intended that right to be enforced" by the Board. To safeguard that right, the Board has adopted a special type of self-determination procedure known as a *Sonotone* election, so named after the lead case. *Sonotone Corp.*, 90 NLRB 1236 (1950). In a *Sonotone* election, the ballot for the professionals includes two questions. The first question asks the professional employees if they want to be included in a unit of professional and nonprofessional employees. The second question asks the professional employees if they wish to be represented by the union or unions involved. *American Medical Response, Inc.*, 344 NLRB 1406 (2005); *Pratt & Whitney, a Division of United Technologies Corp.*, 327 NLRB 1213, 1217-1218 (1999).

III. FACTS AND RELEVANT JOB CLASSIFICATIONS

A. Admissions Department

The Admissions Department, where new patients are evaluated and processed, is open 24 hours a day seven days of the week. Cara MacAleer is the Director of Admissions. Elizabeth Uffner, the Admissions Manager, reports to MacAleer, and supervises the Admissions Department employees. A psychiatrist is on duty in the Admissions Department at all times. The Department is staffed with Medical Health Technicians (MHTs), Assessment Coordinators I (ACIs), Assessment Coordinators II (ACIIs), a Benefits Specialist and a Unit Clerk, all reporting to MacAleer and/or Uffner.[10] There is also an Operator/Receptionist who works in the area who is part of, and reports to, the Chief of Security.[11] Individuals are frequently referred to the Hospital by local hospitals, emergency rooms and physicians. The purpose of the Department is to assess prospective patients to determine their mental health status and decide whether they should be admitted or referred elsewhere. Patients who are admitted spend about four and a half hours in Admissions before being transported to a patient unit. The Admissions Department is located in the Admissions Building and connected to the in-patient unit buildings by tunnel. The Department includes two patient waiting rooms, interview rooms and case management offices.

Admissions Coordinator II

Prospective patients who appear for treatment first go through a security check and are then directed to the Admissions Department for further processing. They are interviewed by an Admissions Coordinator II (ACII), who performs a "level of care" evaluation or assessment that is aimed at determining what treatment the patient might need, e.g., in-patient treatment, drug/alcohol detoxification or rehabilitation, out-patient care, etc. The patient is then interviewed by the psychiatrist, who makes the final determination as to what level of care should be provided. Patients who are deemed to be acute are generally admitted. If the decision is not to admit the patient, the ACII refers the patient to other mental health providers and/or

[10] The parties stipulated that Uffner is a supervisor within the meaning of Section 2(11) of the Act.

[11] There is another receptionist who works in the Scattergood Building. Both receptionists are responsible for handling outside visitors and directing telephone calls to the Employer's main number.

resources, and assists the patient in obtaining that care. Only ACIIs are authorized to do the initial mental status assessment interview.

There are approximately 12 ACIIs. They are salaried exempt employees. Their shifts are generally 7:00 a.m. to 3:30 p.m., 3:00 p.m. to 11:30 p.m., 12:00 p.m. to 8:30 p.m. and 11:00 p.m. to 7:30 a.m. ACIIs are required to have an RN license or hold a master's level clinician degree in psychology, counseling, social work or a related field. However, there is no specific license or certification for the position. Five of the full-time ACIIs and two of the per diem ACIIs hold RN licenses and were referred to in the record as RN ACIIs. Per diem RN ACIIs perform the same work as full-time RN ACIIs. There are approximately five non-RN ACIIs who have advanced degrees.[12] Inasmuch as staff RNs are not regularly assigned to Admissions and prospective patients in Admissions often require medical or nursing intervention, the Employer schedules the ACIIs to ensure that there is always an RN ACII in the Admissions Department who can handle necessary nursing tasks that only an RN can perform. These could include a general screening of patients for medical issues, including those that may require immediate transport to a medical hospital, recommending and/or administering medications to patients,[13] doing blood sugar checks and MRSA cultures, authorizing patient restraint, doing an end-of-shift narcotics count, doing medical status evaluations and, when needed at busy times, performing the in-patient nursing assessment that would ordinarily be performed in the in-patient unit by the nursing staff, and discussing with unit nursing staff which unit would be appropriate for the patient. When an RN ACII is not available for the shift, the Employer assigns a staff RN from the in-patient units or a per diem RN to the Admissions Department for that shift. These substitute RNs have received additional training in admission assessment procedures. Some RNs have transferred to the Admissions Department to be ACIIs. While all ACIIs perform level of care assessments, medical information on assessments performed by non-RN ACIIs must be verified by an RN ACII or the staff psychiatrist. ACIIs also deal with insurance companies regarding coverage and transport new patients to their assigned nursing unit. Full-time RN ACIIs earn approximately $60,000 to $75,000 per annum.[14]

Admissions Coordinator I

There are four to seven ACIs who are staffed around the clock on staggered schedules from 6:30 a.m. to 3:00 p.m., 4:00 p.m. to 12:30 a.m., and 12:00 a.m. to 8:30 a.m. ACIs do not do level of care evaluations. Rather, they are mainly responsible for processing the patients who are being admitted, completing and explaining the necessary paperwork, witnessing the patient's signing of the admission papers and taking the patient's picture for the file and, along with ACIIs and MHTs, transporting the patient to the unit. They obtain patient information, such as psychiatric history, medications and the patient's stated need for treatment. They can obtain the information directly from the patient or others, such as family, friends, treating therapists and other sources. ACIs enter personal, medical and diagnostic information about the patient in the Employer's data base. They begin the clinical chart for the patient, which is later sent to the

[12] The parties agree that all ACIIs are professional employees within the meaning of Section 2(12) of the Act.

[13] In November and December 2011, there were over 6,000 doses of medications that were administered to patients in the Admissions Department.

[14] The record does not indicate what non-RN ACIIs or per diem ACIIs earn.

patient's nursing unit to be incorporated into the nursing chart for the patient. They also prepare a financial folder that is sent to the Employer's Finance Department. ACIs make the initial contact with insurance providers and other third party payers to determine and pre-certify what level of coverage and reimbursement for care might be available for the patient. ACIs work frequently with agencies or others who have referred the patient. They assist patients who are not being admitted in finding other support in their communities. ACIs are hourly nonexempt employees. The record does not indicate their wage rates. All ACIs but one have a Bachelor's degree.

Mental Health Technicians

The Admissions Department includes three Medical Health Technicians (MHTs), one permanently assigned to each of three shifts. The evening shift position is currently vacant. Regular and per diem MHTs from the Nursing Department or the Greystone Program are assigned to shifts in Admissions Department when the assigned MHT is not available. MHTs are required to have one of the following: a Bachelor's degree in any field, 12 college credits and two years of in-patient experience, five years of experience in the mental health field or be a Certified Addiction Counselor. They are not required to have a license. The MHTs take a prospective patient's vital signs soon after his or her arrival in Admissions and reports them to the RN ACII or the psychiatrist as needed. There are two waiting rooms for prospective patients. MHTs are basically responsible for the patients when they are in the waiting rooms. After taking the vital signs, the MHT begins an observation sheet for the patient indicating the patient's continuing status at 15-minute intervals and ensures that the patients are kept safe and well. The MHTs also collect urine samples from the patients while they are in the Admissions Department. MHTs from both the Admissions Department and Nursing Department have frequently covered shifts in each other's department. An ACI or II can cover for an MHT during the MHT's break, principally to do the required 15-minute observations. The MHT on duty is with the patient virtually the entire shift. MHTs are hourly paid in the range $12.75 to $17.53.

Unit Clerk/Secretary

There is one Unit Clerk in the Admissions Department. This Unit Clerk, who works on the day shift, does the shift scheduling for the Department, the physician census that tracks the physicians' daily patient assignments, and the purchase of departmental supplies. The Unit Clerk also prepares a "flash report" for the "flash meeting," a meeting of Hospital management and leadership to discuss new admissions, anticipated discharges and various concerns and issues pertaining to the Hospital community. The Unit Clerk sometimes goes to an in-patient unit to get a document signed or to obtain information needed by the Admissions Department. The Unit Clerk/Secretary is hourly paid in the range $16.60 to $19.75.

Benefits Specialist

The Benefits Specialist is responsible for verifying that a patient has insurance coverage and educating and answering questions from other admissions staff and/or patients regarding insurance coverage. Like the Unit Clerk, the Benefits Specialist sometimes goes to the in-patient nursing unit to obtain information or to get papers signed. She is paid $15.75 per hour and works weekdays on the day shift. The position does not require more than a high school diploma.

B. Nursing Department

Denise Montgomery is the Nursing Executive or Director of Nursing (DON). She is ultimately responsible for nursing care in the in-patient units and enforcement of the Employer's policies and procedures, including performance reviews and evaluations of subordinate staff. Jack Plotkin is the Assistant Director of Nursing (ADON).[15] Maurice Washington is the Tuke Building Manager and Autumn DeShields is the Bonsall Building Manager.[16] They are all RNs by training and experience. The patient units in the Tuke and Bonsall Buildings fall within the Employer's Nursing Department organizational chart. Washington and DeShields oversee the staff work in their respective building. The units are staffed by hourly-paid non-exempt CNs, RNs, MHTs and a Unit Secretary. There are approximately 16 CNs, 50 RNs, 20 per diem RNs, four LPNs, 152 MHTs, eight per diem MHTs and four Unit Secretaries.

The shifts for the Tuke and Bonsall Buildings are 7:00 a.m. 3:30 p.m. (day), 3:00 p.m. to 11:30 p.m. (evening) and 11:00 p.m. to 7:30 a.m. (night). There is one Charge Nurse (CN) assigned to each unit on the day and evening shifts. There is no CN on the night shift, when most patients would be expected to be asleep. There are also seven to eight Administrators-On-Duty (AODs), also known as "off shift Nursing Supervisors," who work the 3:00 p.m. to 11:30 p.m. and 11:00 p.m. to 7:30 a.m. shifts and on weekends, when the Building Managers and CNs are not present. Most nursing staff have regular shift and unit assignments.

There are nursing stations on each unit. The usual staffing for each of the five general adult units and the adolescent unit (when at full census) is two RNs (including the CN) and five MHTs on the day shift and on the evening shift, and one RN and two MHTs on the night shift. The intensive adult unit is usually staffed with two RNs and six MHTs on the day shift and evening shifts, and one RN and two MHTs on the night shift. The older adult or geriatric unit is usually staffed with two RNs, one LPN and three MHTs on the day and evening shifts, and one RN and two MHTs on the night shift. A Unit Secretary works on each floor only on the day shift and covers both units on the floor. The staffing on the weekends is the same with the exception that none of the RNs are designated as CNs.

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[15] Plotkin also identified himself as the Assistant Chief Nursing Officer.

[16] The parties agree that the Building Managers are statutory supervisors.

Charge Nurses

The CN position was established in August 2011. The Employer provided additional training for those who were selected for the positions. Previously, the units were headed by eight nurse managers. The Employer eliminated that classification. CNs are generally responsible for ensuring that the Employer's policies and procedures in the patient units are adhered to, that the patients receive the prescribed care assignments that should be carried out by nursing staff and that the schedule of patient activities is adhered to. CNs provide clinical information regarding patients to psychiatrists, therapists and social workers, and receive information from them. A treatment team meets with the CN for two or three hours on a daily basis to exchange patient information and discuss patient progress. CNs give and receive clinical reports at the shift change. CNs have monthly meetings with the ADON and the Building Managers to discuss nursing procedures and policy. Sometimes Unit Clerks attend the meetings. The ADON also communicates with the CNs by email. CNs do not have offices. They may hold unit meetings with unit staff when necessary. CNs administer medications, do admissions and discharges, make notes and entries in the patient's clinical chart, and run therapy groups. CNs are paid in the range of $27.75 to $39.00 per hour.

1. Assignment of MHTs and staff nurses

CNs assign patients to MHTs and team nurses in the first hour of the shift and CNs fill out patient assignment sheets for the rest of the nursing staff. The assignments to the MHTs include simple tasks such as removal of lint from the dryer, hall monitoring and assigned hours for the 15-minute observation rounds and smoking breaks, urine collection, room checks for safety and environmental compliance and checks for sharp objects. CNs, as well as staff nurses, may also assign other miscellaneous tasks to MHTs as needed. The record does not indicate clearly what criteria the CN uses to make these assignments. It appears that in some cases the CN assigns patients who are grouped together in the same area to an MHT. Frequently patients are assigned to rooms by gender or acuity level. Sometimes a factor in the assignment is regulatory constraints that have to be satisfied or "the clinical presentation." In addition, it appears that patient assignments may be relatively fixed over the period of about a week. The team nurse makes the assignments on the night shift.

2. Transfer of employees

No specific evidence was adduced regarding the transfer of nursing staff. In general, CNs have no independent authority to remove or transfer staff employees from their units for cause. Any concerns that they might have would be submitted to the Building Manager or to an Administrator-On-Duty for a decision. Nor do CNs have authority to rebalance nursing staff in uneven census situations or select staff for reassignment. The Staffing Coordinator makes that decision in consultation with the rotating "pull book." Sometimes the employee next in line to be pulled is skipped over when there are clinical reasons to keep the employee on the unit.

3. Discipline

Although DON Montgomery testified that CNs have the authority to discipline nursing staff employees, there was no evidence of CNs having done so. Rather, CNs were generally instructed that, if they have problems with nursing staff in their units, they should first try to resolve the issue directly with the employee, and if unsuccessful, then to report the matter to the Building Manager. The Employer provided no documentation with respect to alleged disciplinary actions by CNs. Rather, its witnesses testified about incidents that the Employer deemed to be disciplinary. DON Montgomery indicated that CN Deidra Timbers once complained about an employee from the Department of Utilization Management (UM) being habitually late for morning team meetings that are conducted by the CN. The UM Director decided to take no action against the employee, apparently having resolved the issue directly with the employee. DON Montgomery also related another occasion when CN Shanae Stewart informed management of a report that a staff member may have engaged in undescribed inappropriate behavior and that the behavior may have been captured by the surveillance camera. According to DON Montgomery, the surveillance tape was reviewed and the employee resigned. There was no evidence as to what role the CN may have played beyond relaying the report to management. On another occasion, CN Deidra Timbers reported to Building Manager Washington that an MHT was frequently sleeping on the job, creating a safety issue as well as not completing his work. Timbers asked Washington to speak to the employee, thinking the employee would take a directive from Washington more seriously. She made no recommendation regarding discipline. Building Manager Washington investigated the allegation and suspended the employee. There was no evidence as to Timbers's role in the suspension beyond reporting the employee. Building Manager Autumn DeShields testified that she and CN Jen Roth jointly met with a MHT about whom a patient had complained and told the employee that they were aware of the complaint and that she needed to "work on it." There was no indication as to what role CN Roth played in that matter, nor any indication that it was a disciplinary action.

The Employer introduced no disciplinary forms other than a form entitled Supervision/Consultation Note that could be used to document disciplinary action. However, there is no evidence that CNs have actually utilized this form, or any form, in connection with the disciplinary process. In addition, DON Montgomery indicated that all terminations must be reviewed by the Human Resources Department. Other than the employee handbook, which refers generally to a "corrective action process," the record does not contain any detail regarding a formal disciplinary policy, if any.

4. Performance appraisals

The Employer evaluates employees during their probationary period and thereafter on an annual basis. DON Montgomery testified that the CN's role is to assist the Building Manager in the evaluation process. CN Deidra Timbers also testified that the Building Manager told her that he would be writing the evaluations and asked her to provide her opinion and other information

in connection with an employee evaluation. The Employer introduced five evaluations[17] in the record and email directives to CNs that they were obligated to complete the evaluations. Some of the entries, including the ratings, appeared to have been highlighted or completed before they were given to the CN. The record is unclear as to the impact that the CNs' input in this evaluation process could have on the employee's wages and/or tenure of employment.[18] DON Montgomery testified that at times she investigates to determine why employees were rated as they were and also to ensure that the rating is fair. The evaluation is reviewed by the Building Manager, the ADON and the DON and then submitted to the Human Resources Department where merit increases are determined. The Employer put in evidence an RN and an MHT evaluation from late 2010, and the final ratings for these employees. Also, there was no evidence as to how the evaluations affected their wages. No evidence was presented as to who evaluates the nursing staff who work the night shift and on weekends when there are no CNs on duty.

4. Grievance resolution

DON Montgomery testified that CNs have the authority to resolve disputes and "peer conflict" among nursing staff, but there was no specific evidence of CNs having done so.

5. Hiring

DON Montgomery cited one example of an unnamed job applicant who was first interviewed by Building Manager DeShields, who was impressed with the applicant. DeShields then had CNs Jennifer Roth and Joseph Mauro interview the applicant. According to Montgomery, Mauro and Roth also liked the applicant and both recommended that the applicant be hired and the applicant was hired. There was no specific evidence that other CNs have participated in the interview and hiring process.[19]

6. Responsible direction of employees

Regarding accountability, CNs were instructed at meetings, in their job description and in their training that they were accountable for the performance of their nursing units. Although CNs were instructed that their supervisory performance would be evaluated, they have not yet received performance evaluations, and there is no evidence that any of them have been held responsible for the failure of the nursing staff to perform their duties.

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[17] Of the approximately 200+ RNs, LPNs, MHTs and Unit Clerks who would have to be evaluated by the 16 CNs, the Employer presented only five evaluations, four by CN Joseph DeMauro and one by CN Loretta Pacitti.

[18] At the time of the hearing herein, the evaluation of the nursing staff had not been finalized.

[19] The record shows that in the past in order to facilitate a team approach to hiring, some staff nurses and MHTs have participated in applicant interviews.

Registered Nurses

RNs, also referred to as team nurses or staff RNs, do medical and psychiatric assessments on patients. These assessments must be performed by an RN every 24 hours. Psychiatric assessments focus on and document patient factors like suicidality, vulnerability, thought content and the ability to take care of oneself. RNs also administer medications and do therapeutic groups called process groups and medical education groups. Medical education groups focus on educating patients about psychiatric medications that they may be taking, especially the side effects and risk factors related to the medications. RNs do patient admissions and discharges, talk to doctors about the patient's treatment and take the psychiatrist's orders. They also take report at the beginning of the shift. Like MHTs, they do patient observation rounds though not as many as MHTs. Staff RNs can request that MHTs be transferred to a different unit. However, higher supervision independently evaluates and decides whether the transfer is warranted. Only RNs have the authority to authorize patient restraint, although any employee with the requisite training can implement the RN's directive. DON Montgomery testified that RNs could assign to MHTs the usual duties that are associated with their jobs and routine tasks like getting patients out of bed, bathed and other duties as needed. She did not testify as to how RNs would exercise independent judgment in making such assignments. As discussed below, most of the MHT's job is routine and repetitive. In addition, many, if not most of the MHT work assignments that the Employer would attribute to RNs would already have been assigned by the CN. The staff RN on the night shift, who is not a CN, does the patient assignments for the shift, though, because the patients are asleep, the range of assignments to MHTs would appear to be greatly reduced. RNs are paid in the range of $26.75 to $37.74 per hour.

Mental Health Technicians

MHTs are required to have one of the following: a Bachelor's degree in any field, 12 college credits and two years of in-patient experience, five years of experience in the mental health field or be a Certified Addiction Counselor. They are not required to have a license. One of the most important duties of the MHT is to make sure that the patient is safe. Accordingly, MHTs make continuing observation rounds at 15-minute intervals in their units to make sure that the patients are safe, and they document the content of the observation (i.e., where the patient is and what the patient is doing) and/or the patient's status. The observation sheet is part of the patient's medical record. The MHTs also take patients' vital signs and make sure that patients are engaged in "activities of daily living" (ADL), i.e., that the patients gets out of bed in the morning, take care of personal hygiene, clean their rooms and change their sheets, take their meals in the cafeteria or in their rooms, and do not harm themselves or others. MHTs report significant behavioral changes to the nurse. MHTs also run patient psycho-educational groups, which are differentiated from the therapy or process groups that are run by CNs and RNs. Psycho-educational groups are focused on imparting knowledge to participants with respect to ways to deal and cope with common life situations, while therapy groups are focused on eliciting the inner feeling of the patient participants. MHTs also conduct "community meetings," which are attended by all patients on the unit, and at which the participants review goals, rules, complaints and questions that patients might have. MHTs monitor patients when taking

scheduled smoking breaks in the courtyard or visiting outside the patient unit and when they take meals. They also escort patients to appointments at the Hospital or outside the Hospital and perform other patient-related tasks that might be assigned by the nursing staff. The MHTs document those activities in the patient's chart or nursing progress notes. MHTs are paid in the range of $12.75 to $17.53 per hour.

LPNs

The four practicing LPNs,[20] are all assigned to the older adult unit because geriatric patients require more skilled nursing care. LPNs primary responsibility is medication administration, progress note documentation and skilled nursing care, including blood sugar checks, throat cultures, nebulizer treatments and wound care. They also can and do perform many of the same tasks that MHTs perform. LPNs also run medication groups. LPNs are paid in the range of $20.00 to $22.72 per hour.

Unit Clerk/Secretaries

There are four Unit Clerks/Secretaries who answer the telephone, perform clerical work for the units and are responsible for making chart forms available, arranging transportation when a patient is discharged, scheduling outside medical appointments for patients when the appointments cannot be handled in house, and managing the patient discharge room. The Unit Clerk is assigned to two units on one floor and moves back and forth between the units. Unit Clerks are paid in the range of $16.60-$19.75 per hour.

Clinical Integrity Nurse Auditor

There is one Clinical Integrity Nurse Auditor (Nurse Auditor), Maryann Liebertz, who works full-time weekdays in the Nursing Department, primarily on the day shift. The Nurse Auditor reports directly to the DON. The position is salaried and exempt, earning about $65,000 per annum, and requires an RN license. Liebertz's office is located in the Medical Records Department, but she visits the patient care units on a regular basis. The Nurse Auditor has no responsibility for, or involvement in, any patient care. Rather, she audits open records to ensure that nursing staff is adhering to the Employer's nursing policies and procedures and other applicable regulatory requirements. The Nurse Auditor also advises staff when there are deviations or deficiencies in that regard and provides informal corrective instruction as needed. The Nurse Auditor has no authority with respect to discipline of employees. In addition, the Nurse Auditor reports on and makes recommendations with respect to compliance with nursing policies and regulations and performs other nursing research projects as directed by the DON.

The Greystone Program

[20] One Unit Secretary also holds an LPN license.

The Greystone Program consists of two long-term residential homes (Greystone and Hillside) for adult and geriatric patients with chronic and severe mental illness who are unable to care for themselves. Catherine Walker is the Director of the Program. There are two RNs, one full-time and one part-time, and six MHTs who are assigned to the Program. Neither of the RNs is a CN. The RNs report to Walker, who is a Clinical Specialist with RN and MSN (Master of Science in Nursing) degrees. The RNs are responsible for resident nursing care and assessments, medications, and ensuring that the Employer's policies regarding safety, infection control and aesthetic standards are maintained. In addition to their usual duties, the Program MHTs assist in administration of resident medication packets that are prepared by the RN.[21] MHTs at the Program work in the Admissions Department when needed.

C. Per Diem Employees

The Employer employs hourly-paid per diem RNs and MHTs. These per diem employees work in the Admissions and Nursing Departments and the Greystone Program. Per diem employees work under the same supervision and perform the same duties as their regularly scheduled counterparts but do not receive benefits. Per diem MHTs must work a minimum of four 8-hour weekend shifts per month and one shift during a designated winter and summer holiday. Per diem RNs must work two 8-hour weekend shifts per month and one shift during a winter and a summer holiday. The Employer utilizes a computerized bidding process by which per diems bid on available shifts and the Staffing Coordinator[22] decides which per diems to select for particular shifts. Some per diem RNs and MHTs have become regularly scheduled employees and some regular RNs and MHTs have become per diem.

D. Department of Utilization Management

Care Managers

Care Managers work in the Department of Utilization Management, which is headed by Pamela Covey, the Director of the Department. Covey reports to Marlene Douglas-Walsh, the Managing Director of Operations,[23] who reports to the CEO. The Department is responsible for collecting and providing to managed care organizations, insurance companies, other third party payers and government agencies that administer Medicaid and/or Medicare information and documentation that supports the medical necessity for, and justification of, reimbursement for the patient's hospitalization. Covey's responsibilities are to oversee and supervise the activities of the Care Managers, ensure that they obtain proper authorization for patient hospitalization, track denials of authorization and appeals of denials and collect other information for other

[21] The MHTs who work at the Greystone Program were also referred to as "med techs" inasmuch as they receive additional training in the administration of medications to Greystone residents only. MHTs are not permitted to administer medication to patients in the Hospital.

[22] The parties stipulated that the Staffing Coordinator should be excluded from any unit that is found appropriate.

[23] Douglas-Walsh was also identified as the Director of Support Services. It is not clear whether she holds two positions or whether her titles are interchangeable.

departments. Denial of coverage is a critical event in that it may mean that the Employer is not paid for a patient's hospitalization.

Covey holds an RN license as do two of the eight Care Managers. There is apparently no State certification or license for the Care Manager position. Although no advanced degree is required to hold the position, all but one of the other Care Managers has a Master's degree in psychology or social work and experience in a clinical setting. One Care Manager, Alicia Bolds, has a Bachelor's degree. However, Care Managers have the same duties irrespective of their academic credentials.[24] Although the Department is physically located in the Scattergood Building, there is a Care Manager and an office assigned to each patient unit. Care Managers, even those who are licensed RNs, have no responsibility for, or involvement in, any patient care. Rather, they attend the treatment team meeting conducted by the CN. They discuss the treatments plan with the team in order to be able to provide to the insurance companies and managed care organizations support for the patient's continuing hospitalization. They also consult with nursing staff, physicians and social workers to obtain information that is needed to support the hospitalization. Care Managers often have to negotiate with insurance companies with respect to provision of coverage and collect information for in-house quality audits and for Medicare. The Care Managers are salaried exempt employees and work on the day shift, Monday through Friday. The Care Managers who hold RN licenses earn approximately $72,000-$74,000 per annum. The record does not contain the salary ranges for the other Care Managers.

E. Department of Medical Records

Marlene Douglas-Walsh is the Managing Director of Support Services, which includes the Medical Records Department.[25] The position for the Director of the Medical Records Department is vacant. The Director would report to Douglas-Walsh. The Department is responsible for the storage and maintenance of all patient medical records, particularly patient charts. The employees in the Department have no contact with patients. The three classifications in dispute—Medical Records Specialist, Medical Records Clerk and Medical Records Analyst—are hourly paid between $12.54 and $18.45 per hour and require no academic or technical training beyond a high school diploma and some experience.

Medical Records Specialist

The Medical Records Specialist is responsible for generating a chart for new patients. She first checks the Employer's patient records to determine if the patient was previously admitted to the Hospital, in which case the new chart would use the same number as the old

[24] The Employer takes the position that, with the exception of Bolds, Care Mangers are professional employees within the meaning of Section 2(12) of the Act. The Petitioner takes the position that all Care Managers are professional employees.

[25] It is not clear where the Medical Records Department is located. One witness placed it in the Scattergood Building where the Employer's administrative offices are located, while another placed it in the Admissions Building in the basement.

chart. If there are none, she starts a new chart instead of continuing an existing chart. The Medical Records Specialist is the liaison with the vendor that does the Employer's medical transcriptions. She deals with doctors to orient them to the medical records practice at the Employer and to ensure that they can do dictation and that their medical notes are complete and signed. She ensures that all necessary forms are uploaded to the Employer's data base and she orders supplies for the Department, does filing and other miscellaneous tasks as assigned. She leaves the Department infrequently. The Medical Records Specialist works weekdays on the day shift.

Medical Records Clerk

The Medical Records Clerk is in charge of filing and retrieving charts and handling internal requests for a patient's chart, for example, when there is a request for the past chart of a readmitted patient, and also handling external requests for the chart, such as subpoena and related requests. Requested charts are made available in the Department for pick-up, usually by a Unit Clerk. The Medical Records Clerk also reviews a chart that is being prepared for closure to ensure that any noted deficiencies have been corrected. He then enters the chart's completion in the data base and files the chart. The Medical Records Clerk works weekdays on the day shift.

Medical Records Analyst

There are two part-time and one per diem Medical Records Analysts. The Medical Records Analyst prepares the chart for closure at the time of the patient's discharge, making sure that the chart is correctly formatted and noting any deficiencies in the computer record of the chart. The part-time Medical Records Analysts work 16-20 hours a week after 4:00 p.m. The per diem Medical Records Analyst works less than eight hours a week.

The Department also includes Coders who code the charts for billing purposes.[26]

F. Other classifications in dispute

Receptionist/Operator

The Employer employs approximately six Receptionist/Operators who report directly to Darryl Norris, the Chief of Security. One Receptionist is posted in the Admissions Building near the security station and another in the Scattergood Building. The Receptionist in the Admissions Building is staffed around the clock on three 8-hour shifts and in the Scattergood Building from 7:00 a.m. to 9:00 p.m. The Receptionists rotate between both reception desks, and are jointly responsible for answering and distributing incoming telephone calls to the Employer's general number. They provide information to visitors and staff as needed. The Receptionist assigned to

[26] The Coder position is not in dispute. The Employer takes the position that Coders are professional employees within the meaning of Section 2(12) of the Act, and therefore should be excluded from the unit. The Petitioner does not seek to represent Coders.

the Admissions Building also does some computer entry work with respect to preliminary paperwork for prospective patients who appear in Admissions. The Receptionists are hourly paid in the range of $10.76-$13.83. The position requires a high school diploma or GED.

Administrative Assistants

The Employer seeks to include three full-time hourly paid Administrative Assistants (AAs) who work on the day shift in the Department of Risk Management and Performance Improvement and in the Department of Plant Operations.[27] None of the employees have regular patient contact. The AA positions are hourly paid and do not require academic or technical training beyond a high school diploma. Counsel for the Employer represented that AAs are paid in the range of $14.50-$22.75 per hour.

Two AAs, Kathryn O'Dea and Catherine Metzger, work in the Department of Risk Management and report directly to Digpalsingh Rawal, the Department Director. The Department is responsible for the Employer's compliance with governmental regulations that pertain to patient care.

AA Kathryn O'Dea works full-time on the day shift in an office in the Scattergood Building. She is responsible for reviewing the patient incident log on a daily basis and investigating the details of the incident. If appropriate, she reports the incident to the Patient Safety Committee. She also does patient data care collection and reports, and provides other support for Director Rawal, the Patient Safety Committee, the Quality Council and the Employer's corporate office. She has telephone, email and face-to-face contact with nurses and other staff regarding patient incidents that occur in their units.

AA Catherine Metzger has a work station adjoining the Medical Records Department. She is the Employer's primary reporter to "the Joint Commission," a reference to the Joint Commission on Accreditation of Healthcare Organizations, which requires, on a monthly basis, patient care information that is generally obtained from a review of a random sampling of 100 patient charts. The collected information is entered into the Employer's web site, from which it is uploaded to the Joint Commission's web site. Metzger also coordinates the production of charts for various internal audits that occur in the Medical Records Department and for physician peer reviews.

The third AA, Stephanie Lovette, reports directly to Ray Gostowksi, the Director of Plant Operations at Maple Hall, the Plant Operations Building. Gostowski is also the Employer's Safety Officer and supervises other maintenance employees, who work with Lovette. Lovette is responsible for ordering and ensuring the delivery of supplies requisitioned by the patient units. She collects various safety and health reports, including infection control reports, for the Safety Committee and provides other support for the Committee, which meets monthly. The Safety Committee, which includes the DON and two Infection Control Nurses.

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[27] There are two other Administrative Assistants who work in the Human Resources and Administration Departments, whom the Employer contends are confidential and/or managerial employees and whom neither party seeks to include in any unit.

IV. ANALYSIS

A. SUPERVISORY STATUS OF CHARGE NURSES AND REGISTERED NURSES

Registered Nurses

The Employer contends that RNs assign and responsibly direct the work of MHTs on the in-patient units.

1. Assignment and responsible direction of work

As discussed, in *Oakwood* above, at 689, the Board decided that the Section 2(11) function "assign" referred to "the act of designating an employee to a place (such as a location, department or wing), appointing an employee to a time (such as a shift or overtime period), or giving significant overall duties, i.e., tasks, to an employee." It also noted that in the health care setting, the term "assign" encompasses a CN's responsibility to assign nurses and aides to particular patients. However, "assign" for purposes of Section 2(11) does not, under *Oakwood*, refer to ad hoc instructions to perform discrete tasks. Responsible direction refers to the delegation of discrete tasks as opposed to overall duties and that the supervisor faces adverse consequences if the assigned tasks are not performed correctly. *Oakwood* above, at 691-92.

There is no evidence that all RNs are involved in assigning MHTs to particular units or shifts. Only RNs who work on the night shift are in a position to assign patients and delegate tasks to MHTs. CNs assign patients on the day and evening shift. There was no evidence with respect to what criteria specific RNs may have used to assign patients or delegate tasks on the night shift. MHT Jill Chambers, who works on both the evening and night shifts, testified that RNs divide the patients among the MHTs so that the workload is equalized and that patients are generally assigned in groups that are in close proximity to each other, making it easier for the MHT to perform the delegated tasks. According to Chambers, MHTs sometimes divide tasks among themselves, and the beginning of the rotation for the 15-minute observation rounds is assigned to whoever leaves the shift report first. The Board has determined that assignments made on the basis of equalizing workloads are routine or clerical in nature and do not establish the use of independent judgment sufficient to confer supervisory status. *Regal Health and Rehab Center, Inc.,* 354 NLRB No. 71 (2009), JD slip op. at 6-7; *Golden Crest Healthcare Center,* above at 730, fn. 9; *Oakwood Health Care,* above at 697.

As to RNs' use of independent judgment in assigning patients or tasks to MHTs, DON Montgomery testified in summary fashion, without providing specific examples.[28] The record shows that RNs have the authority to instruct MHTs to perform tasks such as checking patients

[28] The Employer did not put in evidence any assignment sheets that were completed by RNs as opposed to CNs.

for sharp objects, performing 15-minute observation rounds for one or more patients, carrying meals from the cafeteria to a patient's room as well as other regularly recurring tasks. DON Montgomery did not testify regarding what criteria RNs would use in making such assignments nor how the assignment of such ordinary and routine tasks could require the exercise of independent judgment. In addition, there was no evidence as to how the assignment of MHTs to monitor sleeping patients on the night shift demonstrates the exercise of independent judgment. The Board has repeatedly indicated that conclusory testimony without supporting detail is not sufficient to establish supervisory status. *Avante at Wilson Inc,* 348 NLRB 1056, 1057 (2006); *Franklin Hospital Medical Center,* 337 NLRB 826, 829 (2002); *Crittenton Hospital,* 328 NLRB 879 (1999); *Sears Roebuck & Co.,* 304 NLRB 193, 194, 199 (1991). In addition, none of the hypothetical assignments and/or delegations of tasks that Montgomery discussed require any particular skill, and it is unlikely that an RN would need to exercise independent judgment in assigning patients or duties in these circumstances. See *Shaw, Inc.*, 350 NLRB 354, 356 (2007); *Ten Broeck Commons*, 320 NLRB 806, 811 (1996). Similarly, there is no evidence that RNs have ever been held accountable for the failure of MHTs to carry out their duties.

Accordingly, I conclude that the Employer has not demonstrated that RNs use independent judgment in assigning patients to MHTs or that they responsibly direct MHTs, and I find that the Employer has not established that RNs are supervisors within the meaning of Section 2(11) of the Act.

Charge Nurses

The Employer takes the position that CNs exercise the supervisory indicia discussed below:

1. Assignment of patients to and responsible direction of MHTs and staff nurses

The evidence established that CNs assign patients to MHTs and team nurses (RNs and LPNs) in the first hour of the shift. However, there was no evidence that CNs used independent judgment in making these assignments. CN Timbers testified that she assigned patients whose rooms were adjacent or otherwise close to one another. This was consistent with MHT Chamber's testimony as to how patients are assigned on the evening and night shifts. There was no evidence that Timbers or other CNs use independent judgment in making patient assignments. CNs also assign specific duties to MHTs, some of which are noted on the assignments sheets. The assignments to the MHTs include simple tasks such as removal of lint from the dryer, hall monitoring and assigned hours for the 15-minute observation rounds and smoking breaks, urine collection, room checks for safety and environmental compliance and checks for sharp objects. The record does not indicate clearly what criteria CNs use to make these assignments. They are common tasks that all MHTs are capable of doing, and there is no evidence that the assignment of such tasks would require the exercise of independent judgment. `Sometimes the assignments are fixed for the week, which is consistent with them being routine. Likewise, there was no testimony establishing what criteria CNs use to assign patients or tasks to the staff RN or LPN, and therefore no showing that CNs use independent judgment to assign patients or specific tasks to the staff RN or LPN. Similarly, while CNs were instructed that they were accountable for the

performance of their nursing units, there is no evidence that CNs have ever been held accountable or suffered adverse consequences for the failure of MHTs or staff nurses to carry out their duties.

Accordingly, I conclude that the Employer has not demonstrated that CNs responsibly direct or use independent judgment in assigning patients to or tasks MHTs or team nurses.

2. Transfer of employees

The evidence does not establish that CNs have independent authority to transfer or effectively recommend the transfer of nursing staff. First, there was no specific evidence of an employee having been transferred by a CN. Rather, the DON and other Employer witnesses testified in general terms about CNs' alleged authority to effect such transfers. Such conclusory evidence is insufficient to establish the existence of supervisory indicia. Moreover, the evidence establishes that the Staffing Coordinator is in charge of transfer decisions. While CNs may make recommendations and requests regarding the transfer of personnel, there is no specific evidence as how such recommendations and requests are handled and whether there is independent review. The selection of employees for transfer appears to be largely controlled by the "pull book," except in the rare case when circumstances establish that the next employee in line should be retained on the unit. Again, however, the record does not contain the details of when and how a CN may have intervened to avoid the transfer of an employee via the pull book rotation. The Board has indicated that reassigning employees from overstaffed to understaffed areas is nothing more than an attempt to equalize workload and does not involve an exercise of supervisory judgment. *Lynwood Manor*, 350 NLRB 489, 490 (2007); *Top Job Building Maintenance Co.*, 304 NLRB 902, 904 (1991). Accordingly, I find that the Employer has not established that CNs have the authority to transfer or effectively recommend the transfer of employees.

3. Discipline

Under Section 2(11) of the Act, individuals are supervisors if they have the authority, in the interest of the employer, to discipline other employees, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment. *Oak Park Nursing Care Center*, 351 NLRB 27, 28 (2007). *Oakwood* and its companion cases do not alter or clarify existing Board standards for determining when alleged supervisors will be found to have the authority to discipline other employees. In this case, the Employer has not carried its burden of proving that the CNs possess the authority to discipline or to effectively recommend discipline of employees.

It is noteworthy that, other than the employee handbook, which refers generally to a "corrective action process," the Employer did not introduce any evidence with respect to the details of its disciplinary procedures, if any, or documentation of specific examples of disciplinary actions. Although there is a form entitled Supervision/Consultation Note, which the Employer said could be used for discipline, there was no evidence that it had, in fact, been used in that fashion. Instead, the Employer's witnesses testified about their general recollection of alleged disciplinary events.

CN Deidra Timbers testified that CNs were generally instructed that, if they had problems with nursing staff in their units, they should first try to resolve the issue directly with the employee, and if unsuccessful, then to report the matter to the Building Manager. With respect to the incident of a Utilization Management employee who was chronically late to meetings in the nursing unit, the record does not, in fact, show that the employee was disciplined. Rather, it appears that the Director of the Utilization Management Department had a conversation with the employee, and that ended the matter. CN Timbers' involvement was limited to complaining that the employee was late for meetings. With respect to the employee who resigned after being confronted with allegations of misconduct based an examination of surveillance tapes, CN Shanae Stewart's only apparent involvement was to alert management that the employee may have engaged in misconduct. Indeed, is not even clear from the record what the basis for Stewart's allegation was. At best, Stewart appears to have only reported what she may have seen or heard. There is no evidence that Stewart had any involvement in the matter after making the report. Mere reporting of alleged misconduct does not establish supervisory status, especially where, as here, higher-ranking officials independently investigated the matter. See *Williamette Industries,* 336 NLRB 743, 744 (2001). With respect to the employee whom CN Timbers claimed was sleeping on the job, the evidence disclosed that Timbers merely asked Building Manager Maurice Washington to talk to the employee, not that Washington should discipline the employee in any particular fashion. Therefore, the suspension of the employees was Washington's independent decision. In these circumstances, Timbers, like Stewart, was merely reporting alleged misconduct to higher authority. With respect to the evidence that Building Manager Autumn DeShields and CN Roth "talked to" two MHTs about their performance, one who was staying beyond her shift and another about whom there was a patient complaint, again, there is no evidence that either employee was disciplined and no evidence that Roth recommended discipline or any other action. Based on the above, I find that the Employer has not shown that CNs have the authority to discipline or to effectively recommend the discipline of employees.

4. Performance appraisals

The authority to evaluate is not one of the Section 2(11) supervisory status indicia. *Elmhurst Extended Care Facilities, Inc.*, 329 NLRB 535, 536-537 (1999). Rather, when an evaluation does not by itself affect the wages and/or job status of the employee being evaluated, the individual preparing such an evaluation will not be found to be a statutory supervisor on the basis of the evaluation. *Franklin Home Health Agency*, 337 NLRB 826, 831 (2002); *Harborside Healthcare*, 330 NLRB 1334 (2000). The Board has held that nurses are statutory supervisors on the basis of preparing evaluations only when there is a direct correlation between the evaluations that they prepare and merit increases received by the evaluated employees. *Trevilla of Golden Valley*, 330 NLRB 1377, 1378 (2000); *Hillhaven Kona Healthcare Center*, 323 NLRB 1171 (1997).

The Employer failed to demonstrate that any employee's wage was affected by an evaluation performed by a CN. Thus, the Employer has not demonstrated that there is a direct correlation between the MHT wage increases and their evaluations by CNs. DON Montgomery asserted that there was a direct result between an employee's evaluation and employee ratings

that were calculated by the Department of Human Resources, but the rating system was not explained and the Employer did not show what actual wage increases employees did or did not receive due to their evaluations. While the Employer put in the record appraisals for an MHT and an RN from late 2010 that purport to show that connection, the evaluations only showed the ratings that the employees received from Human Resources without showing how those ratings affected the employees' wages. Moreover, in 2010, the evaluations were completed by someone other than a CN inasmuch as that classification did not exist at the time. Therefore, the probative weight of those evaluations is questionable. Next, the Employer introduced only a handful of MHT performance appraisals completed by just two of sixteen CNs in late 2011 or early 2012, some just days before the hearing and some of which appeared to have been pre-marked. Thus, the Employer has not demonstrated that all CNs are doing performance appraisals. In addition, the MHT evaluations are apparently still being collected, and it has not been established what further independent review there may be.[29] Therefore, the impact that the performance appraisals may have on final wage decisions is speculative at this point. Accordingly, I find that the Employer has not demonstrated that CN evaluations effectively determine wage increases of MHTs.

4. Grievance resolution

DON Montgomery's limited testimony about CNs having the authority to resolve disputes and "peer conflict" among nursing staff was nebulous and lacking in the specificity needed to find that CNs have the authority to adjust grievances. Accordingly, I find that the Employer has not established that CNs have the authority to resolve grievances.

5. Hiring

The Employer's evidence in support of its position that CNs effectively recommend the hire of employees is limited to an applicant who was hired after first being favorably interviewed by Building Manager Autumn DeShields and later by CNs Jennifer Roth and Joseph Mauro, who also liked the applicant. Since DeShields had already screened, and was impressed with the applicant, the favorable opinions by Roth and Mauro were cumulative and do not necessarily demonstrate that they effectively recommended the hire of the applicant. *ITT Lighting Fixtures*, 265 NLRB 1480, 1482 (1982). In addition, there were no other specific instances where CNs were alleged to have hired or effectively recommended the hire of an employee. An isolated instance of an effective recommendation to hire is insufficient to establish supervisory status. *Kosher Plaza Restaurant*, 313 NLRB 74, 87 (1993). The participation of Roth and Mauro in a single interview of an employee hardly establishes that CNs as a class are responsible for interviewing applicants. Accordingly, the Employer has not demonstrated that the Employer has the authority to effectively recommend the hire of employees.

[29] In this regard, I note that both DON Montgomery and CN Timbers indicated that the Building Managers would play a significant role in the evaluation process. Timbers testified that Building Manager Washington told her that he would be doing the evaluations in 2011 because the CNs were new and that he would ask CNs for information and their opinion. MHT Jill Chambers testified that Washington did her evaluation in December 2011.

Based on the foregoing, I find that the Employer has not established that CNs are supervisors within the meaning of the Act.

B. THE APPROPRIATE UNIT

RN Unit

Both parties agree and Board law makes clear, that an RN unit in a psychiatric hospital is presumptively appropriate. See, e.g., *Charter Hospital of Orlando South*, 313 NLRB 951 (1994); McLean Hospital Corp., 311 NLRB 1100 (1993); *Holliswood Hospital*, 312 NLRB 1185 (1993). Accordingly, I find that the petitioned for RN unit including CNs, is an appropriate unit. The parties agreed and stipulated that RN ACIIs and Infection Control Employee and Health RNs should be included in the RN unit.

The parties disagree as to the unit placement of Care Managers who are also RNs and the Clinical Integrity Nurse Auditor. The Employer, contrary to the Petitioner, would include RN Care Managers and the Nurse Auditor in the RN unit. The Employer asserts that these positions are "clinically related" to the RN unit and they work with RNs in the Nursing Department. The Petitioner contends that these positions should be excluded from the unit because they do not function as RNs or perform any patient care.

Two of the Employer's eight Care Manager hold RN licenses, though the Care Manager job description does not require the Care Managers hold and RN License.[30] All Care Managers perform the same work, and there are no differences in their assigned duties that depend on whether they hold an RN license. Unlike the ACIIs, none of the Care Manager, including the RN Care Managers, perform nursing work of any kind. Rather, the Care Managers are focused entirely on ensuring that the Employer is paid for the hospitalizations, treatment and services that are provided to the patients. They deal extensively with insurance companies and third-party providers. Their contacts with patients and/or nursing staff are limited to obtaining information that is necessary to successfully process insurance claims, which is critical to the Employer's financial survival. Their location on the nursing units is designed to facilitate access to the information that is needed to support a patient's claim for benefits, not to assist in the delivery of patient care. In addition, Care Managers are salaried exempt employees and work in a different department and under different supervision than most of the staff RNs. Accordingly, whatever common interests that RN Care Managers may have with staff RNs fall well short of the required showing that their interests and those of the Petitioner's RN unit "overlap almost completely," and their exclusion would not be so irrational as to result in a "fractured unit." Accordingly, I find that RN Care Managers do not share an overwhelming community of interest with the RN unit, and therefore, I shall exclude them from the RN unit.

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[30] In cases where utilization review/discharge planners were required by the employer to be RNs, the Board has included them from the RN unit, *Pocono Medical Center*, 305 NLRB 398 (1991); *Middletown Hospital Assn.*, 282 NLRB 541, 578 (1986); *Frederick Memorial Hospital*, 254 NLRB 36 (1981); and *Trustee of Noble Hospital*, 218 NLRB 141 (1975), and in cases where utilization review/discharge planners were not required by the employer to be RNs, the Board has excluded them the RN unit. *Charter Hospital*, 313 NLRB 951, 954 (1994); *Ralph K. Davies Medical Center*, 256 NLRB 1113, 1117 (1981); and *Addison-Gilbert Hospital*, 253 NLRB 1010, 1011-1012 (1981).

The Clinical Integrity Nurse Auditor works in the Nursing Department, and is an RN. She audits open nursing records, and discusses with RNs noted deficiencies and ways to achieve better compliance with nursing policies and procedures. Unlike the RN ACIIs, the Nurse Auditor performs no patient care or any of the other duties that staff RNs routinely perform in the nursing units. She spends the bulk of her time reviewing patient records. In addition, she works directly for DON Montgomery and performs various ad hoc nursing research projects for Montgomery, performing more like Montgomery's special assistant than a hands-on RN. The Nurse Auditor is a salaried exempt employee. Although, the Nurse Auditor may share a community of interest with the RN unit, her position is different enough from theirs that it cannot be said that the traditional community of interest factors overlap almost completely. I find that the Employer has not shown that the Clinical Integrity Nurse Auditor shares an overwhelming community of interest with the staff RNs, warranting her inclusion in the unit. Accordingly, I shall exclude the Nurse Auditor from the RN unit.

Nonprofessional unit

The Petitioner seeks a unit of nonprofessional employees limited to LPNs, MHTs and Unit Clerks in the Nursing Department and MHTs in the Greystone Program and the Admissions Department. The Employer contends that the Petitioner's unit is inappropriate because it does not include other clinically related nonprofessional employees.

The core group of LPNs, MHTs and Unit Clerks in the in-patient units work side-by-side in the same department, under common in-patient unit conditions, and common supervision by the Building Managers. They work a common 3-shift schedule and have a common personnel and fringe benefit policy. LPNs and MHTs are both responsible to some degree for recording and documenting patient care and other activities and have daily repeated interactions with the patients. The Unit Clerk, who has less direct contact with patients, is involved in answering the telephone, managing the files that the units maintain, and performing the recordkeeping and other clerical tasks that are critical to the smooth and efficient operation of the unit. The Employer concedes that MHTs, LPNs and Unit Clerks share a community interest insofar as they all work in clinical patient care.

The MHTs in the Greystone Program similarly share a community of interest with the nonprofessional employees in the Nursing Department. Most importantly, the Greystone MHTs share the same job classifications, wages and benefits as their counterparts in the in-patient units, and the Greystone MHTs are also engaged in the around-the-clock provision of patient care, though to a different patient population. There is some evidence of interchange among MHTs from Nursing, Greystone and Admissions, and the Employer appears to assign MHTs wherever they are needed, demonstrating that their regular duties in those areas are more alike than distinct. In addition, the Greystone group homes are on the same campus and not too distant from the Tuke and Bonsall Buildings. Though the Greystone Program does not appear to be functionally integrated with the in-patient units and its employees are separately supervised by the Greystone Director, these factors are insufficient to trump the obvious community of interest among MHTs based on their common classification.

The Admissions Department MHTs share a common classification, wages and benefits with their counterparts in the Nursing Department and the Greystone Program. Like other MHTs, they are charged with around-the-clock systematic observation of prospective patients in the waiting room to ensure that they are safe, and they perform some of the tasks, like taking vital signs and urine samples, and restraining patients when directed, that the other MHTs perform. MHTs from the Nursing Department and the Greystone Program can be assigned to the Admissions Department when necessary.

Based on the foregoing, I find that the nonprofessional unit sought by the Petitioner is an appropriate unit. Under *Specialty Healthcare,* if the petitioned-for unit is deemed to be appropriate, the employer then must show that the employees in the excluded classifications that are in dispute share an overwhelming community of interest with those in the included classifications. It is not enough that the Employer demonstrate that its proposed unit is also appropriate or even more appropriate than the petitioned for unit. Rather, the Employer must show that the community of interest factors of both groups "overlap almost completely" and that there is no rational basis for excluding the disputed employees

The Employer contends that employees in the following nonprofessional classifications share a community of interest with the petitioned for nonprofessional unit that warrants their inclusion in the unit: Assessment Coordinator I, the Benefits Specialist and the Unit Clerk/Secretary in the Admissions Department, the Administrative Assistants in the Departments of Risk Management and Performance Improvement and Plant Operations/Safety, Medical Records Specialist, Medical Records Clerk, Medical Records Analyst, Receptionist/Operator and the non-professional Care Manager in the Department of Utilization Management. Importantly, however, none of these employees are engaged in patient care either directly or as part of a team approach to patient care like the nursing units or the Greystone Program.

The Medical Records Specialist, Medical Records Clerk and Medical Records Analyst work in a different location, under different supervision and under very different working conditions from the LPNs, MHTs and Unit Clerks. These Medical Records Department employees work in a records room, opening and closing patient files and retrieving them when necessary. Unlike the LPNs, MHTs and Unit Clerks, they have virtually no contact with patients, and little contact with the nursing units other than to take file requests. Similarly, the Administrative Assistants have no responsibility for patient care and work outside the patient care units under different supervision. AA Kathryn O'Dea investigates patient incidents and does other work for the Safety Committee. AA Catherine Metzger collects and analyzes patient charts that are selected at random for reports to the Joint Commission, and performs other work related to data collection, analysis and reporting. AA Stephanie Lovette works for the Director of Plant Operations and has duties related to the Employer's Safety Committee. She also handles requests from the in-patient units for supplies. Again, they have little, if any patient contact. The Receptionists/Operators answer and redirect incoming calls to the Hospital and provide general information and assistance to visitors and others. They too have little, if any, significant patient contact. Accordingly, the Employer has failed to demonstrate that any of these employees have an overwhelming community of interest with the petitioned for nonprofessional unit.

With respect to Care Manager Alicia Bolds, Employer contends that she is a nonprofessional employee who should be included in the nonprofessional unit. None of Bolds' duties as Care Manager have anything to do with the delivery of patient care. In addition, she is a salaried exempt employee. There is no basis for finding that Bolds shares an overwhelming community of interest with employees in the nonprofessional unit.[31]

As to other employees in the Admissions Department, the Unit Clerk/Secretary and the Benefits Specialist have virtually nothing to do with patient care. The Unit Clerk does scheduling for the Department, handles physician assignments and has duties associated with the Employer's "flash meeting." The Benefits Specialist deals with insurance issues. Each sometimes goes to the nursing units to get papers signed. The evidence is therefore insufficient to conclude that they share an overwhelming community of interest with the petitioned for nonprofessional unit. Similarly, Assessment Coordinator Is do not share an overwhelming community of interest with the LPNs, MHTs and Unit Clerks. ACIs interact with prospective patients, some of whom are admitted, but only to get basic information to process paperwork and determine insurance coverage. They are not involved in patient care delivery, and unlike the LPNs, MHTs and Unit Clerks, they do not deal with the same patients on a regular basis. Once an ACI has processed a patient who is being admitted, there is little reason to deal with the patient again. In short, their duties and working conditions are not so similar to the Petitioner's nonprofessional unit that the community of interest factors "overlap almost completely" and that excluding them would fracture the unit.

Based on the foregoing, I shall exclude the following employees from the nonprofessional unit: Assessment Coordinator I, the Benefits Specialist and the Unit Clerk/Secretary in the Admissions Department, the Administrative Assistants in the Departments of Risk Management and Performance Improvement and Plant Operations/Safety, Medical Records Specialist, Medical Records Clerk, Medical Records Analyst, Receptionist/Operator and the non-professional Care Manager in the Department of Utilization Management.

Combined RN and nonprofessional unit and *Sonotone* election

The Employer takes the position that, notwithstanding the RNs right under *Sonotone* to a self-determination election, Board policy does not sanction the inclusion of non-professional employees in an RN unit. The Employer cites no applicable authority for this proposition[32] other

[31] Although the parties take the position generally that Care Managers are professional employees, I make no finding in that regard. However, inasmuch as I find that Bolds does not share an overwhelming community of interest with the nonprofessional unit, I also find that the other Care Managers likewise do not share an overwhelming community of interest with the nonprofessional unit.

[32] The Employer cites *Marian Manor for the Aged*, 333 NLRB 1084 (2001), in support of its position. In that case, the Regional Director directed a *Sonotone* election in a combined unit of RN and LPN staff nurses on the ground that the employer used RN and LPN staff nurses almost interchangeably. However, the request for review before the Board did not include, and the Board did not address, the Director's unit determination including all staff nurses. Consequently, *Marian Manor* is not appropriate authority on the question of the combination of RNs and nonprofessional employees. In addition, the Director's Decision in *Marian Manor* was decided under the guidance of *Park Manor*, which the Board has overruled. See *Specialty Healthcare*, supra.

than the Board's determination that RN units are one of the presumptively appropriate units under its acute care hospital unit rule. However, the rule does not suggest that RNs may not be part of a broader unit. To the contrary, the rule states that, "[i]f sought by labor organizations, various combinations of units may also be appropriate." (See National Labor Relations Board, 29 CFR Part 103, Collective Bargaining Units in the Health Care Industry, 284 NLRB 1516, 1597 (1987)). In addition, the fundamental premise of the Employer's position, i.e. that the training, skills and duties of RNs are too different from those of the nonprofessional employees for them to be represented in the same unit, is at odds with Section 9(b)(1) of the Act, which envisions the joint representation of professional and nonprofessional employees in a single bargaining unit, subject to the *Sonotone* election requirement. Thus, the Employer's contention that RNs may not be included with MHTs, LPNs and Unit Clerks lacks merit. See also *Upstate Home for Children*, 309 NLRB 986 (1992) (separate "nurses only" units rejected on community of interest grounds).

I find that the employees in the RN unit and the petitioned-for nonprofessional unit share a community of interest, and therefore, that together they may constitute an appropriate unit, if the RN unit votes for inclusion. As discussed in greater detail above, there is a wide disparity in the wages and educational background between the RN and nonprofessional units, but both units share common fringe benefits and personnel policies, and with the exception of Unit Clerks, are scheduled around the clock. The vest majority of these employees work together in the nursing units, where they are commonly supervised by the Building Managers and where the CNs, RNs, LPNs and Unit Clerks adhere to a cohesive team approach to the delivery of care, working under the same conditions and dealing with the same patient population that defines their unique mission. The RNs and MHTs in the Greystone Program work outside of the Nursing Department, and therefore have different supervision, but they too are connected to the Nursing Department by their common goal of providing patient care. Similarly, significant aspects of the work performed by the RN ACIIs and the MHTs in Admissions are directly related to the provision of patient care. Thus, a combined RN and nonprofessional unit would satisfy the *Specialty Healthcare* requirement that the included employees be readily identifiable and share a community of interest, and the Employer has not demonstrated that the employees excluded from the joint unit share an overwhelming community of interest with those who are included. Accordingly, I find that, subject to the RN's choice on inclusion, the RN and nonprofessional unit together constitute an appropriate unit.

IV. CONCLUSIONS AND FINDINGS

Based upon the entire record in this matter and in accordance with the discussion above, I conclude and find as follows:

1. The Hearing Officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction in this case.

3. The Petitioner claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

5. I find that the following employees constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> ***UNIT A:*** All full-time and regular part-time (including per diem employees who have worked a weekly average of four hours in the calendar quarter prior to the election) Charge Nurses, staff RNs, Infection Control and Employee Health RNs, Greystone Program RNs and RN-Assessment Coordinator IIs employed by the Employer at its facility at 4641 Roosevelt Boulevard Philadelphia, Pennsylvania, excluding all other employees, including managerial employees, non-RN Assessment Coordinator IIs, Care Managers, Clinical Integrity Nurse Auditor, Administrators-On-Duty (Off-Shift Nursing Supervisors), Greystone Program Director, Tuke and Bonsall Building Managers, Director of Nursing (Nurse Executive), Assistant Director of Nursing, guards and supervisors as defined in the Act.

> ***UNIT B:*** All full-time and regular part-time (including per diem employees who have worked a weekly average of four hours in the calendar quarter prior to the election) Mental Health Technicians, LPNs and Nursing Department In-Patient Unit Clerks employed by the Employer at its facility at 4641 Roosevelt Boulevard Philadelphia, Pennsylvania, excluding all other employees, including Recreation Therapist, Assessment Coordinators I and II, Care Managers, Admissions Department Unit Clerks, Benefits Specialist, Receptionist/Operators, Medical Records Specialists, Medical Records Clerk, Medical Records Analyst, Administrative Analysts, business office clerical employees, guards and supervisors as defined in the Act.

VI. DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the employees in the two voting groups found appropriate above. The ballot for Voting Group A will ask:

> 1. Do you wish to be included in the same unit as the Mental Health Technicians, LPNs and Nursing Department In-Patient Unit Clerks employed by the Employer for purposes of collective bargaining?

2. Do you desire to be represented for the purposes of collective bargaining by Pennsylvania Association of Staff Nurses and Allied Professionals?

If a majority of the Unit A vote yes to the first question, indicating their desire to be included in the unit with Mental Health Technicians, LPNs and Nursing Department In-Patient Unit Clerks, their votes will be included along with Unit B's vote in one overall unit. If, on the other hand, the majority of Unit A vote against inclusion, they will not be included in a unit with the Mental Health Technicians, LPNs and Nursing Department In-Patient Unit Clerks. In that event, their votes on the second question will be counted separately to decide whether they wish to be represented by the Petitioner in a separate unit.

The date, time, and place of the election will be specified in the Notice of Election that the Board's Regional Office will issue subsequent to this Decision.

A. Eligible Voters

The eligible voters shall be employees in Voting Groups A and B employed during the designated payroll period for eligibility, including employees who did not work during that period because they were ill, on vacation, or were temporarily laid off. Employees engaged in any economic strike, who have retained their status as strikers and who have not been permanently replaced, are also eligible to vote. In addition, employees engaged in an economic strike, which commenced less than 12 months before the election date, who have retained their status as strikers but who have been permanently replaced, as well as their replacements are eligible to vote. Employees who are otherwise eligible but who are in the military services of the United States may vote if they appear in person at the polls. Ineligible to vote are: 1) employees who have quit or been discharged for cause after the designated payroll period for eligibility; 2) employees engaged in a strike who have been discharged for cause since the commencement thereof and who have not been rehired or reinstated before the election date; and 3) employees engaged in an economic strike which began more than 12 months before the election date who have been permanently replaced.

B. Employer to Submit List of Eligible Voters

To ensure that all eligible voters may have the opportunity to be informed of the issues in the exercise of their statutory right to vote, all parties to the election should have access to lists of voters and their addresses, which may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman–Gordon Company*, 394 U.S. 759 (1969).

Accordingly, it is hereby directed that within seven **(7)** days of the date of this Decision, the Employer must submit to the Regional Office separate election eligibility lists, containing the ***full*** names and addresses of all the eligible voters in both **Voting Groups A** and **B**. *North Macon Health Care Facility*, 315 NLRB 359, 361 (1994). The lists must be of sufficiently large type to be clearly legible. To speed both preliminary checking and the voting process, the names

on both lists should be alphabetized (overall or by department, etc.). Upon receipt of the lists, I will make them available to all parties to the election.

To be timely filed, the lists must be received in the Regional Office, One Independence Mall, 615 Chestnut Street, Seventh Floor, Philadelphia, Pennsylvania 19106 on or before March 14, **2012**. No extension of time to file these lists shall be granted except in extraordinary circumstances, nor will the filing of a request for review affect the requirement to file these lists. Failure to comply with this requirement will be grounds for setting aside the election whenever proper objections are filed. The lists may be submitted by facsimile transmission at (215) 597–7658, or by electronic filing through the Agency's website at **www.nlrb.gov.** Guidance for electronic filing can be found under the **E-Gov** heading on the Agency's website. Since the lists will be made available to all parties to the election, please furnish a total of two **(2)** copies, unless the lists are submitted by facsimile or e-mail, in which case no copies need be submitted. If you have any questions, please contact the Regional Office.

C. Notice of Posting Obligations

According to Section 103.20 of the Board's Rules and Regulations, the Employer must post the Notices to Election provided by the Board in areas conspicuous to potential voters for a minimum of three **(3)** working days prior to the date of the election. Failure to follow the posting requirement may result in additional litigation if proper objections to the election are filed. Section 103.20(c) requires an employer to notify the Board at least five **(5)** working days prior to 12:01 a.m. of the day of the election if it has not received copies of the election notice. *Club Demonstration Services*, 317 NLRB 349 (1995). Failure to do so estops employers from filing objections based on non-posting of the election notice.

VII. RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, NW, Washington, D.C. 20570-0001. A request for review may also be submitted by electronic filing through the Agency's website at **www.nlrb.gov**. A copy of the request for review must be served on each of the other parties to the proceeding, and with the Regional Director either by mail or by electronic filing. Guidance for electronic filing can be found under the **E-Gov** heading on the Agency's website. This request must be received by the Board in Washington by 5:00 p.m., EST on **March 21, 2012.**

Signed: March 7, 2012

at Philadelphia, PA

Dorothy L. Moore-Duncan

DOROTHY L. MOORE-DUNCAN
Regional Director, Region Four
National Labor Relations Board